DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

PHYSICAL EXAMINATION REPORT

Dear Physician or Other Health-Care Practitioner/Professional:

The person you are seeing today receives funding for services through the Division of Services for People with Disabilities. Please take a few minutes to complete Section 2 of Page 2, **PHYSICAL EXAMINATION REPORT FORM** (on reverse side) and return it to the person or staff member attending the examination. This information will assist the provider and division staff in assuring that physician orders and medical recommendations are implemented and included in the person's planning process.

Thank you.

Release of Information:

I _____ am my own guardian and authorize my doctor or other health-care practitioner/professional to complete the attached form and give it to myself or the staff member accompanying the person to the exam.

I _____ am the person's legal guardian. I authorize the doctor or other health-care practitioner/professional to complete the attached form and give it to the person or the staff member accompanying the person to the exam.

This release of information is in effect from: this_____day of _____, 20___ , until the_____day of _____, 20___.

Person's Signature _____ Date _____

Guardian's Signature _____ Date _____

Division/Provider Staff Signature _____ Date _____

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

PHYSICAL EXAMINATION REPORT FORM

Section 1 To be completed by the Person or the Person's Community Living Support Staff

Name	**Address**	**Date**
Person:		Today: ___/___/___
Provider:	Provider's Phone Number:( )-	DOB: ___/___/___
Physician (print or type)	Physician's Phone Number:( )-	

Chronic Problems/Diagnosis:_____

Acute Problems/Diagnosis:_____

Recent Hospitalization (Where)	Dates	Diagnosis
_____	_____	_____
_____	_____	_____

Present Medications ❒SEE ATTACHED	Dose	Schedule and Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies	Diet	Current Immunizations	Special Adaptive Equip.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 2 To be completed by the Person's Physician

Weight_____ Height_____	Resp.____ Temp._____	Blood Pressure_____	Pulse:_____

Physical Examination:_____
Diagnostic Test Results:

Abnormalities		**Describe Abnormalities**
HEENT[1]:	❒yes ❒no	
Pulmonary:	❒yes ❒no	
Cardiovascular:	❒yes ❒no	
Skin:	❒yes ❒no	
Abdomen:	❒yes ❒no	
Genitalia:	❒yes ❒no	
Extremities:	❒yes ❒no	
Spine:	❒yes ❒no	
Neuro:	❒yes ❒no	

Recommendations:_____
_____

FNP[2]_____DATE_____PHYSICIAN_____DATE_____

Acronyms: HEENT[1]: Head, Ears, Eyes, Nose Throat FNP[2]: Family Nurse Practitioner